MDR Tracking Number: M5-04-1754-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 2-17-04. .

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The 3/26/03 office visit was found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed service.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to date of service 3/26/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 22nd day of April 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division
RLC/rlc

NOTICE OF INDEPENDENT REVIEW DECISION

Date: April 12, 2004

MDR Tracking #: M5-04-1754-01
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate.In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic reviewer who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

The claimant allegedly received injury to the neck region as a result of the said work injury dated ___; as claimant was reportedly performing occupational duties as a mechanic when he as the as the said incident occurred of the head/neck injury noted as a hit to the head his head on the trailer. The said incident is noted to have resulted in immediate pain and upper left extremity radiculopathy.

Initial care is assumedly from ___, per progress notes dated 1/02/03 thru 2/05/03; however, no facility or doctor name was referenced on the 2-3 page illegible form (i.e. patient history/intake).

Treatment is documented with ___ who treated, per daily progress notes from 2/24/03 to 5/24/03, with physical modalities and ordered a cervical MRI, which was performed on 2/14/03 with impressions by ___ noted as (1) small to moderate posterior left disc bulge at C6-C7, (2) small posterior central disc bulge at C4-C5 and (3) degenerative foraminal encroachment at C4-C5, C5-C6 and C6-C7.

FCE report dated 2/20/03 by ___ revealing decreased tolerance to functional activities, decreased cervical range of motion and biomechanics, major muscle group weakness and noted claimant as aerobically deconditioned. Recommendations for therapeutic exercise programs and pain management consult upon completion of program, if necessary.

A chiropractic modality review was performed on 2/25/03 by ___.

Additionally, treating doctor SOAP notes were reviewed by ___ inclusive of a one page work status letter dated 3/01/03 confirming off work status due to heavy category with no other position offered or available at this time, by the employer.

Apparently, due to continued symptomology and/or lack of improvement, an NCV/EMG study was performed on 3/26/03 by ___ revealing mild left radiculopathy; recommendations to continue with aggressive physical modalities, medications and active rehab; considerations, if necessary, of future cervical myelogram with CT scan, CPT/NCV (in 2-3 months), pain management evaluation and an ortho or neuro referral evaluation.

Finally, a work conditioning program is noted to have been received, per documentation by ___ for DOS 5/19/03, 5/21/03 and 5/23/03.

No treatment/progress or SOAP notes were available for this review beyond 5/24/03 from ___.

Requested Service(s)
The medical necessity of the outpatient services for date of service 3/26/03; for new office visit/ new patient, code 99244 for the above mentioned claimant.

Decision
I disagree with the insurance carrier and find that the services in dispute were medically necessary.

Rationale/Basis for Decision
It is evident in the diagnostic utilization guidelines that a consultation ***may be*** appropriate in cases where the tester for nerve conduction and/or EMG needs additional history and performs an examination to determine the appropriate testing. The keywords here are ***may be.*** It does not mean "always."

There are times when the treating doctor has supplied enough information through clinical procedures, including current exam and neurological status that additional information is not needed, especially where both the case and the diagnosis, are not complicated and the radiculopathy is supported objectively. The electrodiagnostic tester already knows what testing is appropriate and in these cases, a consultation/office visit is not usually as necessary and probably in some cases, is performed as a formality, since there is a fee involved. It's one of those areas where honesty and integrity are with the tester.

The assumption that consultation is always reasonable and necessary is not accurate and if it were, then the appropriate wording in the utilization guides would have been "a consultation is always necessary," instead of "may be appropriate." Furthermore, documentation must be able to support the necessity for consultation/office visits pertaining to additional information needs.

In this case, I did not find any current re-exam or specific neurological status updates, to assist the electrodiagnostic tester, just prior to the scheduled event in the treating doctor's records supplied by the insurance company.

One may surmise, that the tester did require additional information and examination to accurately assess the case; and after reviewing the treating doctor's notes, I would agree.

Also, MRI did demonstrate the possibility for radiculopathy complaints and since ___ reported this radiculopathy on correlating orthopedics with possible symptom magnification, then this would support a secondary exam assessment to accurately identify testing that would delineate magnification or not.

Further support for consult is in the fact that the electrodiagnostic tester may evaluate a patient, specifically in regards to testing and be able to judge more accurately objective signs, as to whether or not they are significant within the diagnostic parameters, thus limiting overuse testing, while eliminating inferior and sometimes inaccurate reporting, thus leading to more appropriate treatment recommendations. The fact that possible magnification signs were present would be a basis of why this is applicable, in this case.

It was evident that the insurance company, (and others), have routinely paid for this code in the past, on what appears to be a regular basis, as evidenced by review of the tester's supplied documentation. Although, this is not the main reason for a decision in favor of the tester, it does raise questions of why were the prior charges acceptable and this current charge, unacceptable.

The insurance company did not supply any documentation that supported this action or offer any reason as to why they were denying payment for this specific procedure code to be allowed to logically review it. (The explanation code for denying payment, as stated on one of the billing statements supplied by the tester, was listed as "based on peer review, no further treatment is necessary".)

This peer review was based on therapy necessity and not if further testing was reasonable or necessary. Furthermore, if this peer review was to insinuate, that, all future treatment or testing was not reasonable or necessary; one would think that the electrodiagnostic procedure as a whole would be denied. This was not the case.

I would agree that in the majority of electrodiagnostic cases, a consultation/office visit is necessary. Treating doctors as a whole, are not fully knowledgeable on all aspects of these tests and do not provide complete assessments, in terms of which tests maybe appropriate. This is generally left to the electrodiagnostic tester and if properly evaluated, when necessary, then this should hopefully lessen the occurrence of unnecessary and inappropriate tests.